modifies cough. 4. Although limiting waste, this treatment is not especially favorable to increase of body weight. 5. It is without risk, with ordinary precautions. 6. It does not prevent development of other tuberculous outbreaks, or extension of tuberculous mischief. 7. Its anti-parasitic action must not be exclusively thought of, for Headland has described creasote as a sedative, a stimulant of mucous membranes, and as a true astringent.

[In connection with this carefully prepared report should be read that of Dr. C. Beretta on the use of dog's serum in the treatment of tuberculosis, which was presented at the same time at the Section of Therapeutics at the annual meeting of the British Medical Association, held in Bournemouth, July, 1891 (*Ibid.*, p. 1041). He sums up: Dog's serum, also called hæmocyne, in man or in animals, does not seem to have a special curative action against tuberculosis, but it possesses a powerful action, if not against the microbe, at least against its effects. It seems to act as a powerful tonic, and indirectly by improving the general nutrition puts the patient in a better condition to overcome his terrible disease.—Ed.]

MEDICINE.

UNDER THE CHARGE OF

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Mediastino-pericarditis in Children.

Dr. Henry Ashby, of Manchester (*Medical Chronicle*, 1891, vol. xv., No. 3) records two cases of this disease, which illustrate clearly the grave interference with respiration and circulation which this disorder entails.

He points out that the loose areolar tissue of the mediastinum is certain to share the same pathological fate as the structures or organs with which it comes into relation.

The inflammatory process may arise in the lymphatic glands at the bifurcation of the trachea, in the lung, or the pleura. The pericardium is nearly always implicated, either primarily or secondarily. Post-mortem it is often impossible to say where the process originated. The consequent matting together of all the important structures in the mediastinum—by means of a cicatricial tissue, which is often of cartilaginous toughness—must necessarily greatly impair the movements of the heart and lungs. Hence among the effects of mediastino-pericarditis, œdema, ascites, and chronic hepatic congestion are prominent.

The greatest effect appears to be exerted on the hepatic system, leading to enlarged and nutmeg liver, with portal obstruction and gradual ascites, and in some cases to a secondary cirrhosis of the liver, from long-standing congestion.

Clinically, the early symptoms are usually indefinite. A pericardial or exocardial rub may be detected. In most cases ascites is the first marked symptom. Associated may be some œdema of face, or distended cervical veins, suggesting some obstruction to the return of blood to the lungs.

Sooner or later a smooth or irregular and bossy enlargement of the liver may be felt. Some cases are very chronic, and are relieved for a time by tapping; but sooner or later general œdema supervenes. In other cases—tubercular ones especially—the course of the disease is more acute, owing to extension of the tubercular process to other parts. Careful examination of the chest may reveal an increased area of dulness over the sternum and front of the chest where extensive matting of the anterior edge of the lungs and pericardium to the surrounding structures has taken place.

The weakening of the pulse during inspiration, on which much stress has been laid by some writers, was not observed in either of Ashby's cases.

The condition is one which may easily be overlooked. But it may be well to bear its characters in mind in the presence of cases of ascites with hepatic enlargement in young children.

The Dyspnœa of Advanced Bright's Disease.

Dr. Graham Steele contributes an article to the *Medical Chronicle* (1891, vol. xv., No. 1) to support the contention that this dyspnœa is due to heart-failure rather than toxæmia.

The author does not question the part played by "renal inadequacy" in imposing impediments to the circulation, but maintains that the eventual failure of the left ventricle thus entailed is the chief exciting cause of the dyspnœa in question. It differs in no essential point from the dyspnœa of heart disease quite apart from kidney disease, whereas, in the author's experience, it bears little or no resemblance to the irregularities of respiration, apart from lung disease, which occur in the "typhoid state" of continued fever, where we might fairly look for traces of toxæmic dyspnœa.

The dyspnœa in question is usually associated with other evidence of disturbed circulation, and no safe reliance can be placed on the distribution of the œdema as serving to distinguish renal from cardiac dropsy. The frequent occurrence of pulmonary apoplexy and the remarkable relief afforded by morphine hypodermatics are mentioned as favoring the cardiac rather than the toxæmic theory.

A Significant Fact in the Diagnosis and Interpretation of the Albuminuria of Adolescents.

Under this title Dr. Clement Dukes, Physician to Rugby School, contributes an interesting paper (*Lancet*, 1891, No. 3564) on the disease known as "functional albuminuria," "cyclic albuminuria," "intermittent and remittent albuminuria," and so forth. The claims of these various terms to represent the disease are severally discussed and dismissed as misleading or inadequate. "The only name that will be really appropriate to this disease is one which designates its actual state as a hyperæmic or an inflammatory change in the vascular system of the kidney, or a hyperæmia depending upon a neurosis of the nervous supply (vasomotor) to the vascular system of the kidney."

The writer prefers the term "early albuminuria" as being most free from objection, although in some cases the state thus indicated may have existed on and off for some years.

It is quite clear that as long as the renal hyperæmia lasts, the liability to the transudation of serum through the over-distended capillaries must continue. It is also manifest that this exudation only occurs when there is any special stress on the circulation, as in assuming the vertical position after prolonged rest, or during active exertion, or after food. Undoubtedly "early albuminuria" is as pathological as any other disease; and, like the early stage of any other disease, may be transient and recoverable. In the author's opinion it is the habits of human beings which are cyclical, and not the disease. "If human beings roosted during repose in the upright position on perches, like the natural order Gallinaceæ, the disease in question would possess no cyclical character."

The albuminuria is present or absent only intermittently at first, except, perhaps, in the very first instance, when, if the cause has been severe, it remains persistent for a time day and night, whether the position of the body be vertical or horizontal, and however carefully the regimen may have been selected. Also, as the case advances, the albuminuria usually becomes confirmed.

The "significant fact" arose in the following manner: It has been a long-established rule at Rugby that the whole school should meet together for prayers in the school chapel at 7 A.M. An alteration was made in this custom a year or two ago, when it was settled that on two mornings each week the school should assemble in the large hall to enable the head master to address the boys on various common school subjects at the conclusion of prayers. It was not deemed necessary to provide seats for these "fifteen-minute meetings."

The arrangement was in existence for a year or two, during which time the following events occurred:

"While it was exceedingly rare for a boy to faint during morning prayers in chapel, it became a common occurrence when prayers were held in the large hall where the boys had to *stand*. It was at first naturally assumed that the cause resembled that of the fainting incidental to militia training and volunteer encampments, especially church parades, through the constrained position of 'standing at attention.' (Are these similar cases, undiagnosticated as yet?) Then it was assumed that it arose from the hall being hot and ill-ventilated compared with the chapel. But when I found that it was not the delicate boys who fainted, and that the sufferers had hard, rigid pulses, I at once saw that it was owing to early albuminuria; and, on analysis, this supposition proved to be the fact in nearly every instance. I have already referred elsewhere[1] to such cases, but here we had a most marked class of them—boys getting up at 6.40 A.M. and rushing down to school. If they assembled in chapel where they could sit, faintness rarely occurred. The same set of circumstances existed, with the exception that the boys were required to stand for a few minutes, and thus by this differential examination the cause was at once discovered and the boys submitted to treatment. But seats have now been provided, and my diagnostic helpmate has failed me, so that the cases have to be traced in other and less pronounced ways. Could a more classical set of circumstances be presented, not only for the purpose of diagnosticating cases, but also for their interpretation? Here we had a large number of boys going to bed and lying in the horizontal position for about eight hours and a half, and suddenly assuming the vertical position in the morning, often accompanied doubtless by a quick run of a hundred yards to school, and a flight of stone steps to be mounted on the mornings when they assembled in the large hall, and the circulation proving itself unable to meet the altered circumstances, and failing in the attempt. Is it not, therefore, perfectly manifest that these early cases of albuminuria, as I have already endeavored to show, arise from the condition of the circulation pure and simple? Any such stress upon the circulation, such as active exertion, will under similar circumstances reveal the presence of albumin in the urine.

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[1] British Medical Journal, May, 1880.

"The following points present themselves as the result of this consideration of the subject: 1. It is not safe to make a diagnosis in any patient without an examination of the urine. 2. Are not all cases of early albuminuria, in their early stages, identical with the class of cases I have described? 3. If so, it is perfectly clear that these cases of early albuminuria, which are so common in the young, constitute the early stage of what eventually may become developed into the chronic disorganization of the kidney which is termed Bright's disease. 4. Would it not be well to come to some understanding as to its nomenclature, so that a uniform and appropriate name may be assigned to this disease, and that it may cease to be termed 'functional'?

"The gist of the whole matter seems to be this: That where the hyperæmia of the kidneys is severe, the albuminuria is persistent, in whatever position the body may be placed, whether at rest or not, and whatever diet may be partaken; while, if the hyperæmia be slight, from the cause having been trivial, or from a severe attack which is passing away, then the albuminuria only shows itself when the body assumes the vertical position, or under exertion, or after a full meal; but if the hyperæmia be prolonged, however slight in degree, the albuminuria gradually becomes persistent, owing to the permanent dilatation of the bloodvessels, and tends to destruction of the kidneys."

THE ACTION OF DEAD TUBERCLE BACILLI IN THE LIVING BODY.

After considering the investigations of Buchner, demonstrating that a septic suppuration can be induced as a result of the so-called chemotactic influence of certain proteid matters, such as the bacterio-protein of the cell-body of microörganisms, vegetable casein, and certain of the decomposition products of animal tissue, PRUDDEN and HODENPYL (*New York Medical Journal*, 1891, Nos. 23, 25) detail the results of a study of the effects produced in rabbits by the injection of dead tubercle bacilli, sterilized and freed from the metabolic products of bacterial activity. Bacilli obtained by culture on agar and in bouillon were washed with sterilized distilled water and boiled for from an hour and a half to four hours in a small quantity of sterilized water or two to four hours in a fifty per cent. glycerin solution in water, and filtered. The precipitate, washed and made into an emulsion with sterilized water, was injected into rabbits subcutaneously, into the pleura, into the peritoneum, and into the veins. In a considerable proportion of cases in which the injection was made, subcutaneously as well as into the pleura and peritoneum, small local abscesses developed in from two to six weeks. Each abscess was encapsulated and contained pus-cells, granular detritus, and readily stained, well-formed tubercle bacilli, together with involution-forms. Inoculations of guinea-pigs with the pus were followed by negative results. Attempted cultures also failed. When the emulsions were injected into the veins, bacilli could, at the end of twenty-four hours, be found in the capillaries, principally of the lungs, liver, and spleen. In the course of a week or two, the bacilli had largely disappeared from the bloodvessels, except in the lungs and liver. Nodules, composed of epithelioid, giant, and small spheroidal cells, and containing tubercle bacilli, could be detected in the lungs. In the course of from three to five weeks the number of nodules had increased, occasioning an appearance simulating that of miliary tuberculosis. In the liver, as early as the third week after the injection, swelling of the endothelial cells of the capillaries and islets of newly formed cells, containing bacilli, were found. Later, nodules resembling those in the lungs became visible. The number of bacilli contained in the nodules was smaller as the interval following the injection was longer. In no case was caseation or proliferation of tubercle bacilli observed. The purity of the results was confirmed by control experiments. Repeated attempts to isolate from the bacteria the peculiar protein to which are ascribed the results obtained were unsuccessful.

A CASE OF ACUTE PERFORATING OR ULCERATIVE AORTITIS IN WHICH THE BACILLI OF ANTHRAX WERE FOUND.

The case is recorded by DR. THOMAS OLIVER (*Lancet*, 1891, No. 3558).

A watchmaker, aged thirty-six years, was admitted to the infirmary with a greatly enlarged heart and much pain in the left chest and arm. There was a double aortic murmur, the diastolic being loud and cooing, and distinctly audible to the patient. There was also a loud blowing systolic mitral murmur and slightly pericardial grating at the apex and base of the heart.

The pain was more acute than that usually encountered in cases of mitral and aortic regurgitation. Tincture of convallaria gave some relief, but the pain and distress were eventually entirely relieved by one-eighth-grain doses of cyanide of zinc.

He subsequently attended for several weeks as an out-patient, and then died quite suddenly one day while out walking.

"The heart weighed twenty-four ounces. The aortic valves were incompetent; left ventricle extremely dilated and hypertrophied; myocardium very pale, gray, and mottled; mitral orifice dilated, but valve segments healthy.

On still closer examination, the aortic valves were seen to be quite healthy, but the aorta immediately above the orifice was dilated, and a distinct pouching was noticed just above the valves. Over a small area which lay between the mouths of the two coronary arteries, and which extended upward for nearly an inch and a half, the lining membrane of the aorta was extremely red; it was soft and ulcerated, and in two places was gangrenous. From the centre of this patch a small pouch protruded outward. Its wall was as thin as ordinary writing-paper; it was bluish-red and soft, and its floor was perforated by an opening the size of a large pin's-head. A plate of atheroma lay close upon the mouth of the left coronary artery. In my note of the necropsy, and which I shall interpose here, I find it stated: 'This inflammation and ulceration of the aorta is unlike anything that I have ever seen. It resembles ulcerative endocarditis; it has evidently been very acute, and has spread over a considerable surface. It seems to have begun as an acute aortitis which has rapidly run on to ulceration and necrosis.'"

The specimen was referred to Dr. Sims Woodhead, who reported that abundance of bacilli were found in the sections bearing the closest resemblance to those of anthrax.

The patient, so far as is known, was never in contact with animals suffering from splenic fever.

"The lungs in my patient were practically healthy. As the necropsy was limited to the thorax, I can offer no opinion upon the state of the intestinal mucous membrane. His position in life would not bring him into contact with rags, nor is it likely that he could have worn clothing belonging to anyone who had suffered or died from anthrax, no cases of such disease having occurred in this district."

The Etiology of Tabes Dorsalis.

To his previous contributions upon the subject, Erb (*Berliner klin. Wochenschrift*, 1891, Nos. 29, 30) adds the results of painstaking observations upon three hundred and seventy further cases of tabes dorsalis from his own practice. The cases are divided into three groups: those occurring in the better class of patients, those in the lower classes, and those in women. In the first group there was a history or there were present manifestations of syphilis in 89.2 per cent. of the patients; in the second group, in 76 per cent.; and in the third, in 89.5 per cent. In three hundred cases among the better class, the first symptoms appeared in from one to five years following infection in 12 per cent.; from six to ten years, in 37 per cent.; from eleven to fifteen years, in 25 per cent.; from sixteen to twenty years, in 14 per cent. On the other hand, inquiry into the antecedent history of five thousand five hundred cases of widely varying disease in males, disclosed the remarkable fact that but 22.5 per cent. were syphilitic, and 77.5 per cent. not syphilitic. Other causes that were effective in conjunction with syphilis, but which, alone or associated, were of minor importance, were exposure to cold, inordinate muscular activity, sexual excesses, trauma and neuropathic tendency. It is thus demonstrated that in the vast majority of cases tabes is a sequel of syphilis, and that syphilis is by far the most important, the most common, and the most potent etiological factor in tabes.

TWO CASES OF ACROMEGALIA.

PEL (*Berliner klin. Wochenschr.*, 1891, No. 3) reports the case of a girl, twenty-five years old, who had been perfectly well prior to a fright resulting from a fall. Soon after the accident she complained of headache and sensitiveness of the eyes to light and wind. Some weeks later, there were otalgia and tinnitus aurium and sharp pains in the gums; then rheumatoid pains in the back, scapular region, and extremities, with paræsthesiæ, particularly at the tips of the fingers and toes. Headache was sometimes so severe as to induce vomiting. The symptoms were aggravated by the sudden death of a brother, and the free intervals became shorter in duration and fewer in number. In the course of a little while it was observed that the face, hands, and feet were gradually increasing in size. The mental condition was one of depression. There was muscular weakness. There were excessive thirst and profuse perspiration. The appetite was impaired, the bowels torpid. There was occasional vesical tenesmus. Menstruation, previously regular, was absent. There was loss of flesh. The body-length was five feet five inches, the body-weight one hundred and thirty-eight pounds. The appearance was anæmic; otherwise the nutrition seemed maintained. The large size and the shape of the head, as well as the large size of the hands and forearms, were striking. The enlargement of the hands and fingers was regular, so that no deformity was evident. The increase in size was due almost exclusively to hypertrophy of the bony parts. The shape of the face was changed, the lower jaw projecting forward. The occipito-mental diameter was nine and a half inches, the diameter twenty-seven inches. The nose was large and broad; the lips, especially the upper, were large and thick; the right malar bone was prominent; the forehead low. The enlargement of the lower extremities was not as great as that of the upper. The patellæ, the crests of the ilium, the clavicles, and the vertebræ were hypertrophied. The sense of smell was imperfectly developed.

LONG (*Lehigh Valley Med. Mag.*, 1891, No. 3) reports the case of a laborer, forty-eight years old, in whose history only the development of an abscess at either hip, at an interval of ten years, appeared of interest. There was long-existing constipation and transient headache. Enlargement of the hands had been noticed for seventeen years. The skin was of a dirty-yellowish color. The hands, feet, and face were disproportionately large; the face presented the characteristic elliptical contour, otherwise the head was normal in size and shape; the forehead receded from the prominent eyebrows; the nose was large and broad; the lower lip was thickened and everted; the malar bones were prominent; the lower jaw was massive, projecting forward; the tongue was large and broad; the neck was short and thick, and the head inclined forward, as the result of a cervico-dorsal kyphosis. In the hands and feet the hypertrophy involved the bones and the soft parts; the forearms and legs were also somewhat enlarged; the enlargement was the more pronounced upon the right side. The thorax was abnormally large. There was total blindness, with atrophy of both optic nerves. The body-length was five feet nine and a half inches; the body-weight two hundred and sixty-two and a half pounds; an increase of seventeen pounds in twelve years.

THE LESIONS FOUND IN A CASE OF SENSORIAL APHASIA WITH RIGHT HEMIOPIA.

DEGERINE (*L'Abeille Méd.*, 1891, No. 15) reported to the Société de Biologie the result of the necropsy in the case of a patient who had for several months presented complete verbal deafness and verbal blindness. Hearing was otherwise preserved. While vision was acute, there was a right hemiopia, for on moving an object from right to left before the eyes of the patient he did not perceive it until the middle line had been passed. There was complete agraphia so far as concerned spontaneous writing or writing under dictation (verbal deafness impairs this test), but the power to copy was fairly well preserved. The motor faculty of speech remained, but language was incoherent and paraphrasic. There was no trace of hemiplegia and no appreciable alteration of general sensibility. A few days before death, stupor, and finally coma, was manifested. There was found at the necropsy, on the external surface of the left cerebral hemisphere, a yellow patch, commencing in front of the posterior half of the inferior two-thirds of the ascending parietal convolution, leaving intact the fissure of Rolando. It involved the entire base of insertion of the parietal as well as the vertical *plis de passage* uniting that convolution to the superior parietal, following quite exactly the inter-parietal scissure. It likewise involved the entire inferior parietal convolution (supra-marginal gyrus and angular gyrus), extending into the posterior portion of the first and second temporal convolutions and the second occipital convolution. The centres for auditory and visual memory of words were thus destroyed. The softening extended through the subjacent white matter down to the ventricular walls, destroying the radiations of Gratiolet, and thus accounting for the right hemiopia. The frontal lobe was absolutely intact, and Broca's convolution examined microscopically did not give evidence of granular bodies.

Degerine calls attention specially to the paraphrasia which existed in this case, as demonstrating once more how necessary is the preservation of auditory images to the proper functioning of Broca's centre. The discrimination between paraphrasia and motor aphasia is important, and in this case enabled the integrity of Broca's convolution to be affirmed during life.

TREATMENT OF YELLOW FEVER BY COLD-AIR BATH.

GARCIA (*L'Abeille Méd.*, 1891, No. 16), according to a letter from the French consul at Santiago, Cuba, proposes to use the metallic casket as an *ante-mortem* apparatus, and in the treatment of yellow fever. His apparatus, which is open at one side, is made of zinc with double walls, 10 centimetres (4 inches) apart, the space being utilized for the reception of ice. It is 2 metres (say 6½ feet) long, and in section 1.10 metres (say 3¾ feet) square. As soon as the disease is recognized the patient receives a laxative and is placed in the casket. The temperature of the enclosed air varies from 0° C. (32° F.) to 10° C. (50° F.). Garcia believes that the cold not only plays the part of an antithermic agent, but that it sterilizes the chamber and produces a "lavage of the blood." The external air on entering the casket is chilled, and its vapor is at once condensed; a part of the condensed moisture freezes and is deposited on the zinc. The other portion remains in suspension about the patient, and is rapidly absorbed by the cutaneous and mucous surfaces. Entering the blood it dilutes the soluble toxic products this fluid contains, and by increasing blood-pressure promotes their excretion by diuresis. Of twenty patients thus treated only two died.

Le Roy de Méricourt, who read the Consul's letter to the Academy of Medicine at Paris, refrained from any expression of opinion.

THE BRAINS OF TWO APHASICS AND ONE DEAF-MUTE.

LUYS (*L'Abeille Méd.*, 1891, No. 15) presented to the Biological Society of Paris the brain of a soldier of forty-eight years, who, after falling from his horse upon his head, exhibited left hemiplegia without disturbance of sensibility. Speech being impossible, he wrote with the right hand intelligent responses to questions. He used that hand habitually for all purposes, and had never been left-handed.

At the necropsy there was found a notable difference in weight between the two cerebral hemispheres. The right weighed 220 grammes and the left 287 grammes. The left hemisphere was well formed and showed no lesion. The right hemisphere exhibited a great loss of substance, principally in the region of the insula. The gray matter was replaced by a yellowish areolar tissue. The area of destruction was not arrested here, but extended somewhat like an enlargement and prolongation of the parallel fissure. The base of implantation of the third frontal convolution was interrupted at the level of the ascending frontal. Nevertheless the frontal and parietal convolutions remained intact. The first temporal convolution was destroyed throughout its entire extent. The inner surface of the right lobe did not, from a morphological standpoint, show any appreciable lesion. The thalamus was slightly atrophied. The corpus striatum was not laid open, but the depth of the lesion which had practically removed the insula permitted it to be determined that the extra-ventricular portion was notably atrophied. This observation seems to show that the speech faculty is not exclusively located in the left hemisphere and the third frontal convolution. Luys queries whether aphasia of traumatic origin has a different evolution from aphasia of "spontaneous" origin.

The same author exhibited the brain of an idiot girl, aged five years, whose death had been due to acute pulmonary disease. The child had been of medium stature; she had never given any sign of intelligence; she was docile, appeared to hear what was said to her, but was completely incapable of speech. The brain was large, and the convolutions presented very few folds. The right lobe showed no morphologic deformity. The right third frontal convolution was normal; the left third frontal was characteristically malformed; instead of branching, like its fellow, from the base of the ascending frontal, it branched from above like a division of the second frontal. This conformation, with absence of speech, is new evidence in favor of Broca's theory.

A third brain shown by Luys was that of a female deaf-mute, aged twenty-two years. The left third frontal convolution was completely atrophied, being reduced to a curvilinear fold. Its point of insertion upon the base of the ascending frontal was interrupted, and at that point replaced by an irradiating prolongation, like a bifurcation of the second frontal, which had taken on exuberant development. The right third frontal followed the normal configuration.

THE ETIOLOGY OF EPILEPSY.

WALTON and CARTER (*Boston Medical and Surgical Journal*, 1891, No. 19, p. 485) have made a study of the connection between epilepsy and infantile convulsions. By careful scrutiny and elimination of doubtful cases, they were able among two thousand five hundred and thirty-nine cases of all kinds applying at the neurological department of the Massachusetts General Hospital, to isolate one hundred and thirty-three cases of epilepsy—5.25 per cent. In time of onset, they were divided as follows: From birth to five years, twenty cases (15 per cent.); from six to ten years, eighteen cases (13.5 per cent.); from eleven to fifteen years, twenty cases (15 per cent.); from sixteen to twenty years, nineteen cases (14.33 per cent.); from twenty-one to thirty years, thirty-five cases (26.33 per cent.); from thirty-one to forty years, twelve cases (9 per cent.); from forty-one to fifty years, three cases (2.25 per cent.); from fifty-one to sixty-five years, four cases (3 per cent.); unknown, two cases (1.5 per cent.). Of seventy successive cases of pure epilepsy in hospital and in private practice, in which careful inquiry was made as to the occurrence of convulsions in infancy, both in the patient and in brothers and sisters, nine commenced in infancy and became continuous, fifty-six presented no history of convulsions in childhood, and five only presented a history of convulsions in infancy followed by a period marked by an absence of convulsions. It was found that among the brothers and sisters of epileptics, convulsions in infancy were more common than among the epileptics themselves. Of one thousand children consecutively taken at random from society, Walton and Carter elicited a history of convulsions in infancy in one hundred and eleven. It has been estimated that there are about six epileptics in every thousand of population; as convulsions in infancy are observed in one of fourteen cases (five in seventy) of epilepsy, the two affections occur coincidently once in not less than 2000 individuals; and as convulsions in infancy are observed in 222 of every 2000 (111 in 1000) individuals, the chance that a child presenting convulsions in infancy will develop epilepsy later in life is 1 in 222. The conclusion to be arrived at is that epileptics are at least not more likely than others to have had convulsions in infancy, and that, conversely, a child that has had convulsions in infancy is not more liable than any other to develop epilepsy later in life, after a period marked by freedom from attacks has removed the case from the class of epileptics in which the convulsions begin in infancy and become continuous.

TONSILLITIS; PERICARDITIS WITH EFFUSION; PUNCTURE.

SHATTUCK (*Boston Medical and Surgical Journal*, 1891, No. 19, p. 491) has reported the case of a woman, twenty-four years old, who was seized with tonsillitis, and subsequently developed pain and swelling in several joints, with feverishness, pain in the præcordium, and dry cough. On examination the area of cardiac percussion-dulness was found to be enlarged and a pericardial friction-sound was heard near the apex and on the aortic area. In the further progress of the case the condition became so critical that by means of a trocar and canula plunged into the fifth intercostal space on the right, three inches from the median line, about an ounce of bloody, serous fluid was removed. An endeavor to aspirate in the fourth intercostal space on the right, two and a half inches from the median line, was unsuccessful. As a few days later the symptoms were not relieved, the trocar was introduced into the fifth intercostal space on the left, four and a half inches from the median line, and a half-ounce of serum withdrawn. On the following day the trocar was introduced into the fifth interspace, on the left, at the anterior axillary line, six and a quarter inches from the median line, but no fluid was obtained. Ultimately, despite the occurrence of the pulsus paradoxus and of delirium, and the development of friction-sounds on both sides of the chest, the patient slowly improved; a systolic murmur, heard at the apex, however, persisting. As convalescence was about to set in, it was noticed that not only was the action of the heart abnormally frequent, but also that the thyroid gland was enlarged and that there was well-marked tremor, although the eyeballs were not prominent.

SURGERY.

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CASE OF COMBINED PYLORECTOMY AND GASTRO-ENTEROSTOMY FOR CARCINOMA OF THE PYLORUS; RECOVERY.

JESSETT reports (*Lancet*, London, vol. ii., No. 17, 1891) the following case: Female, aged thirty-eight, married, complaining of vomiting more or less frequent for some months, accompanied with localized pain and general weakness. The bowels were constipated. A tumor connected with the pylorus was easily made out. The diagnosis of obstruction of the pylorus, probably of a malignant nature, was made, and operation advised.

The patient consenting, the operation was done as follows: An incision three inches in length was made in the middle line from the umbilicus upward. The tumor was easily seized and brought out through the wound.